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THE INSANITY OF DOUBT.

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INSANITY of doubt is a form of mental disturbance which is brought about by certain disturbances of the psychical processes, to which the various names of insistent or fixed ideas or imperative conceptions have been given. The imperative conception or representation (*Zwangsvorstellung*) plays as important a part in the genesis of the insanity of doubt as the delusion does in the genesis of paranoia. Therefore this form of mental disturbance has often been termed the "malady of fixed ideas," and before studying it, these fixed ideas or imperative representations must be considered.

Westphal defines them as "those representations which enter into the foreground of consciousness without and even against the volition of the individual affected, who, in other respects, is still possessed of an intact intelligence. They are not brought about by any affective or emotional condition. They cannot be dispelled. They prevent the normal current of ideas. The patient recognizes them as abnormal and foreign, and opposes them with his entire consciousness." Although this definition serves in many cases, it excludes too much. The mental obsession by some overpowering emotion cannot, of course, be classed in the same category as the

ordinary imperative representation, but, nevertheless, the ordinary representation is not always free from some affective or emotional element. Wille, moreover, points out that in certain cases the intelligence does not remain intact.

In this instance, as in many others, hard and fast lines have been drawn which are not justified by the facts. As will be shown later, the boundaries of the imperative conception or of the insanity of doubt itself are by no means rigid. Insanity of doubt shades off, with all gradations, from healthy mental action on the one hand to the more pronounced types of mental disease on the other.

Imperative representations in a mild form are not uncommon in health. We all of us know how a phrase or a tune sticks in the mind against our will and often to our annoyance. After an evening at the card-table it sometimes happens that the combinations of the cards will follow me to bed, and persist in my mind for some time before sleep comes, and the same is true of other games. Another form, also common in health, is the impulse to suicide which every one feels, especially in the impulse to jump from high places. Not long ago I heard of a young man who, knowing nothing previously of such impulses, was suddenly forced to jump from a height of some thirty feet. He fortunately landed in soft earth, and, on reaching the ground, had not the slightest idea why he jumped, except that he "had to." Others have impulses occasionally to perform some absurd act, in violation of the social proprieties. These impulses are transitory, and are excited only by the presence of an opportunity for gratifying them. Impulses to other overt acts, murder, arson, and the like, are much less common in health.

From these slight and common forms of imperative representations the transition is easy to the more severe and longer-continued yet still transitory forms, such as are seen in cases like that reported by Luys, where a young accountant, after very severe work and fatigue, found himself involuntarily repeating his calculations. "The cerebral machine had been going with too much force to stop," and this involuntary toil was continued for several weeks before the patient recovered.

These forms arise from the exhaustion of the healthy brain; in other cases we have to do with the morbid action of an invalid brain, and here the imperative representations may be permanent, and give rise to much more serious conditions; they then become the true pathological dominant ideas which form the basis of the insanity of doubt.

As an example of these imperative representations, I will cite the case of Mrs. R., a lady of considerable intelligence and fair education, a public reader, aged 46, who consulted me in April, 1886. There was a marked psychopathic heredity; one aunt had the fear of contamination, another believed she had committed the unpardonable sin. The patient herself had always been nervous and a victim of migraine. For six or eight months she had had much headache, "a distressed feeling at the base of the brain," and other neurasthenic symptoms. In addition she was impressed by the idea that everything was corruptible and transitory; when she saw anyone she recognized all the anatomical details, bones, muscles, blood-vessels and nerves, she could not help seeing them and thinking of them; and she constantly thought of the connection between mind and body. She recognized the foolishness of such thoughts and realized the danger of persisting in them, yet she was utterly unable to control them.

Griesinger, who was one of the first to call attention to this condition, cites several cases, among them one of a lady who constantly questioned herself as to the why and wherefore of everything. "Why do I sit here? Why do men go about? What does this chair signify? Why do men come into being? Why are there men? " and similar questions. Another of his patients was continually questioning "why this man was so large; why he was not as high as the room; why men are only as large as they are; why they are not as large as houses; why there are not two suns and two moons, etc." One of Ball's patients believed that he had vanished, and that all about him was unreal, and constantly questioned himself about it, having an absolute loss of the feeling of identity. Buccola reports a case from Tamburini's clinique, where the patient had to know the course which bank-notes took after they were issued. Legrand du Saulle tells of a

woman who had the idea that some one might fall from a window into the street when she went out, and she constantly put questions to herself in regard to the results of such an accident. Another of his patients questioned about colors, why grass was green; why the sky was blue, etc. Höstermann tells of a man who was constantly tempted to insult the crucifix by some blasphemous act, and cases similar to this fill the old legends of the saints.

These represent the early or rather the simpler states of imperative representations. When the idea becomes still more insistent it forces the victim to perform certain actions in accordance with it. Dr. Johnson's trick of touching the posts and of entering the room with one foot always first are well-known examples of this. One of Ball's patients, remembering that thirteen was an unlucky number, next thought that it would be dreadful were God thirteen, and, to avert this, he constantly repeated "God thirteen, infinity thirteen, eternity thirteen." Hammond tells of a woman who had to search all parts of her room repeatedly lest detectives should be hidden there. Westphal cites the case of a man who began to speculate about paper, then he thought that he might commit some crime and write his confession on paper which might be found and put in evidence against him; thus he was led to cherish every scrap of paper to avert this disaster. Baillarger reports the case of a man who, if any woman whom he saw was pretty, was impelled to find out certain facts about her, her age, antecedents, manner of life, etc. If he was told that she was not pretty he had no need of this information. One day he left Paris for a distant city, and, on arrival, he asked about the ticket-seller at Paris. His companion unguardedly said that he had forgotten to look at her, and so they had to return to Paris at once to settle the matter. Charcot and Magnan have reported a case of "onomatomania," where the patient feels the necessity of recalling some word, and can get no rest until he has done so.

Wille classifies imperative representations as either absurd, senseless or utterly foolish, or entirely natural and comprehensible, but false. As an example of the latter class

he mentions a lady who was beset by the idea of her husband's infidelity, although she firmly believed in his fidelity.

Westphal divides the imperative representations into three classes; the first, where they are merely theoretical and have no influence upon the actions; the second, where the patient is compelled to perform various acts by reason of his dominant ideas; and the third, where idea and act are so bound together as to give rise to the so-called impulsive acts.

Tamburini's classification is similar:

1. Simple fixed ideas, insistent ideas proper, in which the anomaly of ideation is limited purely to the field of intellectual operations, a field purely theoretical, without being manifested externally or passing into action (metaphysical insanity, insanity of calculation, first stage of the insanity of doubt.)

2. Ideas accompanied by feelings of fear and by an emotional state of anxiety. These ideas may be more properly termed emotional ideas, in which, as a necessary consequence, there is a passage to action, imperative acts (second stage of the insanity of doubt, delirium of touch, mysophobia, etc.)

3. Ideas which can more properly be called impulsive, in which the idea so penetrates and unites with the impulsive act that it is very often of a grave and dangerous nature (impulsive ideas, homicide, suicide, etc.)

These classifications I have cited for convenience, and I shall return to them later. At present we must discuss the pathogenesis of these representations.

Consciousness is the sum of present sensations, including representative and re-representative sensations. In other words, at any given moment certain sensory cells in the cerebral cortex are actively engaged in performing their functions, that is, they are in a state of active stimulation; while other cells are either totally inactive or in very feeble activity. Thus, as I write, certain sensory cells that receive impressions from the sight of the objects about me, from the noises of the street that come through my window, and from the contact of the objects near me, certain motor cells that hold the body in position and preside over the movements of

writing, and certain more complex intellectual cells or combinations of cells in which are stored up certain ideas, all these cells are in a state of functional activity. Furthermore I am conscious that certain other sensory cells are ready to act, being now slightly stimulated by associations with the cells in present activity, and, were I to stop writing, they might take on more active functions and inhibit the action of the former set of cells. The idea that this paper must be written is, for the present, the dominant idea, the imperative representation which inhibits the action of the second group. In the healthy brain the sway of such a dominant idea is usually temporary. It arises from association or from external impressions, and may be replaced by some other idea with more or less ease. At present, with no urgent need of finishing writing, it would be a very simple process to stop,—the entrance of a patient, a certain weariness of writing, or the attraction of a novel could easily bring about a cessation of my work, and there would be merely a dim idea in the background of consciousness that the duty was still to be performed.

Now in the healthy brain, as we all know, there are many ideas more or less present to our consciousness, which have no effect upon our actions and but little upon our thoughts. Among them are the feebly insistent ideas of which I have already spoken. Their genesis cannot always be easily traced; they may be re-representative ideas excited by some obscure association, or they may arise from external impressions. In the "invalid" brain the same processes are going on, but here some group of cells, some "ideational centre," has been aroused by some pathological process to unwonted activity. The idea may be any of the absurd ones already cited. In each case that individual group of cells continues to act, it dominates consciousness, and inhibits the action of other cells, and finally the nervous energy extends to the motor cells, and produces a discharge. The patient performs some act in accordance with his idea. "In the malady of fixed ideas," says Buccola, "the anomaly of the association of ideas is due to the anomalous functioning of a few groups of cells, which, not diffusing their energy, vibrate with such

preponderance as to impede, as we say, the contemporaneous and active manifestation of the other groups of the cortex, with which they ought to be in harmony to impart to the mind a sound and perfect tone."

I do not wish to be considered as thinking this condition akin to epilepsy (oddly enough one of Griesinger's patients had had convulsions), but there is a curious analogy to be drawn between the victim of the malady of imperative representations and that form of epilepsy described by Hughlings Jackson, which is due to organic brain disease. Some of us may have had the opportunity of watching the victim of the latter affection during a seizure. He is perfectly conscious of his surroundings, he is aware and he tells you that a seizure is coming on, he feels the signal symptom, the sensory aura in his hand, he watches the muscles of the arm pass into a state of tonic and then of clonic spasm, and, although he knows everything that is going on, it is as much beyond his control as are the movements of Jupiter's moons. So it is with the victim of the malady of imperative representations. He knows that he has a dominant idea that he is in danger of contamination, he recognizes that it is utterly absurd, but yet that idea dominates every other in his consciousness, and finally is expressed by repeated acts of purification, which often he is as powerless to control as the epileptic is his convulsions.

The very curious case reported by Berger is of interest in this connection. The patient, who wrote out a full account of his mental symptoms, had paroxysmal attacks, beginning with a period of metaphysical quibbling (*Grübeln*), and passing to a state of double consciousness, where the psychical processes on one side were calm but on the other were of a tumultuous character. In addition to the psychical symptoms the face became flushed, and there was a profuse sweating, and at times symptoms of motor irritation, contraction of certain muscles. One of these attacks came on in sleep and was dreamed of. Berger, however, although recognizing the analogy between this and epilepsy, opposes the idea of any connection between the two affections—an opinion in which he is sustained by Westphal.

The insanity of doubt is based upon imperative representations, but, as will readily be perceived, it is connected with only a portion of these representations. The mild insistent ideas which occur in the healthy brain and the insistent ideas resting largely upon an emotional basis which are common in melancholia are to be excluded on the one hand. The third class of representations in the classifications of Westphal and Tamburini, where idea and act are so bound together as to the so-called impulsive acts, belongs to the class of impulsive insanities. Furthermore, the imperative representation has certain connections with delusions which will be spoken of later.

This form of insanity was recognized before we had any clear ideas about the imperative representations upon which it is based. Esquirol[1] reports the case of a girl who feared lest she had carried away something valuable from the place she had visited, and therefore undertook endless brushings and ablutions to prevent it. It is commoner in women and among the more intelligent classes, and is seen perhaps more frequently outside of an asylum. The imperative representations upon which it is based may develop suddenly or gradually, and finally they dominate the patient's whole existence, inhibiting all other forms of thought or action. After a time the patient may be compelled by them to perform certain acts, often of an absurd character. He may be aware of his situation and realize the unreasonableness of his ideas, but all to no purpose. Hence the affection is sometimes termed paralysis of the will. There is usually but little emotional disturbance, and delusions are not very common. The case rarely terminates in dementia.

Ball has classified the different clinical types of the insanity of doubt as follows:

1. The metaphysical, where the patient constantly questions himself in regard to transcendental problems, God, eternity, and the creator.

2. The realistic, where the patient questions about less important matters, why men are not as large as houses, why there is but one moon, etc.

[1] Esquirol. Des maladies mentales, ii, 63.

3. The scrupulous, where the patient is in constant distress lest he has done something he should not, and therefore he has to repeat and re-repeat every act or perform many foolish and trifling acts to avert the consequences of wrong-doing.

4. The timorous, who fear to compromise themselves, and take endless precautions lest harm should come.

5. The calculating type, where the patient must count or multiply everything.

6. The patients who fear contamination, who shrink from contact with external objects, and are compelled to perform endless ablutions (*folie du doute avec délire du toucher*, mysophobia).

Emminghaus has given a classification which seems more comprehensive, making three principal groups:

"1. Fixed ideas in an interrogative form, a marked necessity of questioning; which comprises the so-called, 'mania of why,' metaphysical insanity, (*Grübelsucht*, Phrenolepsia erotematica), and the first stage of *folie du doute*, (Meschede has shown that this morbid questioning is always purposeless and about useless things.)

"2. Fixed ideas of multiplication, or morbid necessity for calculating; arithmomania, insanity of calculation.

"3. Fixed ideas with anxious hypotheses; which comprise agoraphobia and the allied forms of morbid fears, and the second stage of *folie du doute*."

Neither of these classifications is satisfactory for the simple reason that the imperative representations which form the basis of the insanity of doubt are of so endless a variety as to render any attempt at classifying them nugatory.

Legrand du Saulle, to whom much of our knowledge of one of the forms of insanity of doubt—*folie du doute avec délire du toucher*—is due, has divided the course of the affection into three stages. In the first stage the patient is susceptible, exacting, dreamy, egotistical and timorous, yet in full possession of his reasoning powers. He is filled with morbid thoughts, he begins to inquire into the reason for every trifling thought, or act, or object about him. With that comes a lack of confidence, a distrust of his own powers, a need for verifying

everything he does, of re-reading everything he writes, a constant repetition of words and acts, and an exaggerated scrupulousness in the most petty actions. In this stage the reasons for his scruples and his actions are often concealed. It corresponds to the first division of the imperative representations in the classification of Westphal and Tamburini.

"This period," says Tamburini, "is ordinarily distinguished by the spontaneous, involuntary, and irresistible productions of some series of thoughts upon indeterminate, theoretical, and sometimes ridiculous subjects, without any illusions or hallucinations. This series of thoughts is brought to the patient's consciousness with interrogations, demands put continually to himself, a profound and constant sentiment of doubt, a species of monotonous rumination, obstinate and oppressing him by the same ideas, and sometimes with a mental representation of certain images which excite persistent pre-occupations. The sole external effect of this inward struggle is merely the necessity of frequently repeating certain acts, upon which the doubt still extends without ever being satisfied or convinced. Therefore the patients are in a state of continual inward hesitation, they are powerless to subtract this incessant labor from their thoughts, which therefore never arrive at any definite result; they are disquieted, impatient, and always plunge still deeper into a struggle which is fatally sterile; therefore they become gloomy, susceptible, egotistical, and exacting. Lacking confidence in themselves, they verify numberless times whatever they do, control whatever they say, read and re-read whatever they write, and take a quantity of precautions for every act which they perform. The ideas by which their mind is tyrannized vary according to the persons, their education, the environment in which they have lived, etc. Some question continually about metaphysical subjects (so-called metaphysical insanity), about the existence of God, creation, religious dogmas, the more general and fundamental theorems of physics, mathematics and other sciences, and sometimes about futile and inconclusive arguments; others are obliged to multiply all the objects they see or think of (insanity of calculation); in other cases the patient is tormented by the doubt that he has not done a

thing well, he has not counted money right, or concluded some negotiation properly, etc., and he is obliged to repeat the same act again and again, or else the doubt and pre-occupation return (insanity of doubt proper). In this period the patients usually conceal their trouble or confide it only to the physician or some intimate friend." Legrand du Saulle, however, places the dividing line between the first and second stage at the point where the patient begins to reveal his doubts. In this stage Westphal thinks that there is little or no emotional disturbance, except as it may arise secondarily. When the patient confides his trouble to anyone, however, he is in urgent need of another's will to enable him to overcome his dominant ideas, and to reassure him of his doubts. The manifestations of his questionings or of his ideas are often paroxysmal. Wille attempts to draw the line between sanity and insanity at this point, where the imperative representations are transformed into imperative acts. In the same way the man with hallucinations is accounted sane as long as he perceives his hallucinations to be such. Although legally this distinction is of value, it does not affect the case in any other way. Each man has an unhealthy brain, and the distinction is merely one of degree.

In the second stage of the insanity of doubt the patient begins to reveal his distress to all his friends, to give prolix recitals of his doubts, to put endless questions, and to require constant re-assurance. This for a time may relieve his perplexity, but it soon returns. There are often periods of distinct excitement attended with or preceded by praecordial or epigastric distress. The suffering becomes more intense, and emotional conditions become more pronounced. In mysophobia the ablutions become constant; it takes hours to make a single toilet. Cases of doubt are common, and both in this and in the first stage remissions are often noted. "This period," says Tamburini again, "which is usually initiated by the urgent need of revealing the patient's sufferings and giving long descriptions of them, is characterized essentially by the fear of touching certain or all objects, fearing to be soiled or poisoned, or injured in some way; the patient avoids touching them, or provides himself with gloves, hand-

kerchiefs, etc.; if he be forced to touch the objects dreaded he has palpitations, anxiety, cold sweats, and sometimes convulsive phenomena, which enter upon the scene and may even go on to syncope; the patients call these attacks their crises. This fear often originates from an instinctive aversion and dread of certain animals, rats, cats, or dogs, and the dread of the latter may even reach the degree of true terror, by exciting the idea of rabies, and it generally compels the patient to perform all the characteristic acts of mysophobia. . . . . The strange and characteristic acts performed by these patients are accompanied by continual monologues and doubts, if the washing has been sufficient, if every trace of filth has been removed, if they have touched new soiled objects, etc., but not content with their own affirmations they seek the assurance of others and oblige the persons about them to repeat certain stereotyped phrases which alone have the power to re-assure them for the moment. Withal they never succeed in being truly convinced and satisfied, since the doubt always re-appears with equal force and insistence."

Finally the patients lose confidence in their assurers. They still see the unreasonableness of their doubts, but the doubts have still greater dominion over them. The doubts are constant instead of being paroxysmal, the victims shut themselves in their houses or in their rooms, and live in their ideas and fears. Their anguish increases, "they are a prey to continual agitation, they do not read or write, and pass the greater part of their time in the midst of timorous irresolution and vague apprehensions, which keep them in a state of almost complete inertia. They are easily fatigued merely from speaking to others, while they often soliloquize in a low voice, or move only the lips with a low whisper; yet in spite of these symptoms, which would seem to indicate a complete weakening of all the mental functions, they never, or hardly ever fall into true dementia, remaining in this state unchanged for years, to the end of their sad lives." (Tamburini.) Here the mysophobist neglects his person, seldom changes his linen, and sits clothed in rags.

Such is the accepted picture of the stages of the affection and its onward progress, but it seems questionable whether

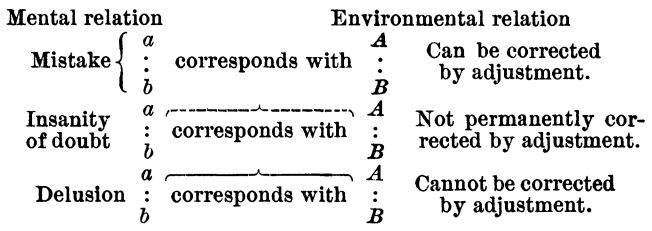
there is any true progress through the various stages. That all these classes exist is not disputed, but it is certainly wrong to say that because a patient has mysophobia, and performs acts of purification, he is therefore in a more advanced, and consequently in a more hopeless condition than a patient who simply questions.

In order to get a clearer idea of the perversion of the mental processes in this affection, we must refer to the formula of thought presented by Mercier.[1]

Mental relation		Environmental relation
a		A
⋮	corresponds with	⋮
b		B

In health we find that our concepts of the relation $a:b$ correspond perfectly with the environmental terms, $A:B$, or if not, the process of adjustment being intact, we can bring them into harmony. Thus the mental relation "a is b" is compared with the environmental relation, "A is not B," and the adjustment may be made at once, the mistake is noted. In the delusions of insanity, however, the disordered process is in the process of adjustment itself, so that correct thought becomes impossible; the patient can no longer see that the mental relation is out of harmony with the environmental relation, that "a is b" differs from "A is not B." Now the abnormality of the thought process in *folie du doute* lies between these two. In health the want of adjustment is detected at once, and need not be repeated. In the delusion the want of adjustment cannot be detected, no matter how often it is repeated. In *folie du doute* the want of adjustment is perceived, but not realized; it is apprehended, but not comprehended; the victim must compare and re-compare, and although he sees the lack of adjustment, he is never sure of it. The accompanying scheme, modified from Mercier, will show this point more clearly, the bracket pointing out the point of disturbance:

[1] Mercier, The Nervous System and the Mind, p. 251.



To take a concrete example: the healthy man gets his hands dirty and duly washes the dirt off, or, if he be a surgeon about to do a laparotomy, he washes his hands with the special precautions of disinfection; the mysophobist, recognizing not only the fact that his hands are now dirty, but the possibilities of dirt, is not satisfied with washing them once or twice, but must repeat the process indefinitely; the victim of the delusion believes not only that his hands are dirty, but that no washing can cleanse them, that he is a source of corruption to the world.

The imperative representation is thus seen to occupy that position between the normal ideational process on the one hand, and the delusion on the other; and its malady, *folie du doute*, stands between the healthy reasoning process, and paranoia. Again it must be insisted that there is no fixed line of division. We have seen how the healthy insistent idea may pass by all degrees into the insane insistent idea, and the insane insistent idea may finally cease to be recognized as false, just as the hallucination finally ceases to be recognized as false, and the idea becomes the delusion. Thus a patient of Meschede had finally hallucinations and delusions of persecution; one of Wille's patients, who had the insistent idea that everything was damned, finally developed true hypochondriacal paranoia. Schüle[1] classes *folie du doute* as a disease of the defective constitution and states that part of the cases go on to delusional melancholia. Westphal classes it as an abortive *Verrücktheit*, while Krafft-Ebing[2] goes farther and sets it down as merely a variety of paranoia, *primäre Verrücktheit in Zwangsvorstellungen*, ordinary paranoia being *primäre Verrücktheit in Wahnideen*.

[1] Schüle, Klinische Psychiatrie, p. 18, 468.
[2] Krafft-Ebing, Lehrbuch der Psychiatrie, ii, p. 10.

Krafft-Ebing[1] has also analyzed these two forms of insanity, showing the common features in their development, and the distinctions between them. Paranoia and *folie du doute* are alike in the following respects:

"1. Heredity or original neuropsychopathic constitution, which can almost always be detected, and which points to original functional anomalies of the nervous centres.

"2. Slow invasion of the disease, reaching back to puberty.

"3. The primary onset of anomalies of representation, deprived of any affective basis.

"4. Representations of a strange and unassimilable character, projected from the depths of consciousness and connected with consciousness by associations, either as imperative representation or delusion as the primordial creation of a diseased brain.

"5. The typically congruous nature of ideas in different individuals, as in mysophobia or the congruous delusions (of persecution) in paranoia.

"6. The purely constitutional, but permanent and stationary character of the two affections.

"7. Neither of them ends in dementia."

They differ in these respects:

"1. In paranoia the ideas are of a delusional character, while fixed and insistent ideas treat only of simple formal alterations of the process of ideation.

"2. In paranoia the morbid ideas are soon taken up and assimilated by the consciousness, but the fixed ideas always remain more or less completely extraneous, shut out, and opposed to consciousness, which is still perfectly clear, and to the reason and the will, which are dominated by them. Hence come the pain and distress to which the patients are a prey, which arise in part from the sad consciousness of the formal disorder of ideation, in part from the nature of the fixed ideas which are almost always painful and sometimes dangerous to themselves or others, and in large part from the impossibility of getting away from these ideas and acts." Here, again, I believe that too sharp a distinction has been

[1] Krafft-Ebing, Allg. Zeitschr. f. Psychiatrie, XXXV., 1878.

made, as the *folie du doute* and paranoia evidently blend.

I have traced the growth of the imperative representation from its simple manifestation in the healthy brain to its full development in the invalid brain. The factor of doubt, which plays so important a part in these cases, has also its analogy in health. At times even in the healthy brain there will come phases of doubt, when we are uncertain whether we have properly performed some act, whether the door was locked when we left the house, or whether the letter just mailed was properly directed and stamped. A striking instance of the sort was related to me by a friend remarkably free from any psychopathic taint. It often happens that he does scientific work in the evening at the Agassiz Museum. When he leaves for the night he puts out the gas and then stands and counts slowly up to a given number until his eyes are used to the darkness, in order that he may detect any spark of fire that may have started while he was at work. This is his invariable custom, but it sometimes happens that when he goes back home so strong a feeling of doubt comes over him lest he may that once have omitted to do this, that he is uncomfortable until he returns to the museum to make sure. The act has become so automatic, probably, that the higher centres take but slight part in it, and so it is not recalled to the memory like some unusual action; but—and here is the point where the action of the healthy brain differs from the brain of the victim of *folie du doute*—when he has gone back and repeated his accustomed act, thus assuring himself of its performance, he has no further trouble, while the insane doubter must verify and re-verify and verify again, and yet at the end he is still in doubt.

Turning back to the other end of the scale, where the insistent idea approaches the delusion, where abortive paranoia (*folie du doute*) approaches paranoia, the following case shows clearly the mixture of insistent ideas and delusions, the combination between insanity of doubt and paranoia.

Margaret K., a servant-girl, unmarried and forty years of age, came to me at the Boston City Hospital in May, 1886. How much of a psychopathic heredity there was it is hard to say, for the patient knew but little of

her family; one sister, she said, was "not right in her mind," being cross and quick-tempered. The patient herself was small, rather anæmic, moderately well nourished, and was much marked by small-pox. She consulted me "because her head was upset." She was unable to give the date of her attack of small-pox, but it was during her early years. Except for that she had always been well. Her sexual desires had always been very strong, and she had practiced masturbation at various times. As a girl she had allowed various men to take liberties with her, but she had never permitted coitus. For fifteen years or more she has been a victim to various forms of doubt, and she has had sundry imperative representations. She has had the belief that her employers were wronging her about her wages, and that she has had money which has disappeared. She is unwilling to say anything about her losses because she does not know whether she has actually had the money; she thought she had it, but she is not sure; she cannot be sure that anyone took it, she thinks they did, but she is not sure; someone offered to restore the money to her, but she was unwilling to take it, because she was not certain whether it was taken, or whether she ever had it; the restoration might be to try her, and it might cause her injury if she accepted it. She thinks the money that disappeared was stolen, but she does not want to say that it was, neither will she state the amount. If she suspects anyone, and listens, she thinks she hears voices talking, but of this she is doubtful. She is disposed to think everything sinful, she is disturbed about the future life on account of her sins, and fears that the dead may return. When it is suggested that the dead don't want to return from heaven and can't return from the other place, she says "Yes, I know it; they can't come back, but yet I think about it." On the next visit she returns to the same subject as before. She says she has been careless and talked about her neighbors, which is a sin. When asked if she had ever said anything bad about them, she says, "No, I don't know that I have, I don't remember, but sometimes I think I might have." She wants to tell her faults over and over again at the confessional before she is satisfied. She is afraid if in a lonely street in the dark lest some one should kill her. She thinks men want to abuse her, as she has seen them with their clothes unbuttoned. At another time she said she did not think she had ever indulged in coitus, but she couldn't be sure. One day she asked if there was not such a thing as sin with a dog; she had heard of it and was anxious about it; she had never committed it, at least she thought she had not, but sometimes it seemed as if she might have. When she went to bed she had to have the clothes arranged in a particular fashion as a protection; if she did not she thought it was sinful. It was a sin. too, if she did not lock her door. All this and more would be repeated at each visit, and when she was assured that she had done nothing wrong, that these ideas were all nonsense, and she need not worry about them, she would say, "Yes, I know it, I don't think I have done anything wrong, and yet sometimes it seems as if I

had." As might be expected, her doubts and her imperative conceptions continued, assurances to the contrary having but slight effect, and after a time she passed from observation.

Insanity of doubt may develop at almost any age; it is commoner among women and in the better classes, the case just cited being an exception. Among the predisposing causes are acute diseases, anæmia, masturbation, sexual excesses, overwork, anything that may weaken the nervous centres and depress their tone. The majority of writers regard it as distinctly a psychical degeneration like paranoia, and claim that the psychopathic taint and bad heredity are the chief factors in the origin of the disease. This is undoubtedly true of the severer cases, but Cowles has shown that in the milder types the hereditary taint is absent. From our study of the development of their conditions, such an opinion must be accepted. There is no hard and fast line between the fully developed insistent idea, (the pathological obsession), and the normal obsession, so that between the two must lie many cases of slighter degree, with no psychopathic taint. Moreover, the insanity of doubt has been shown to be a lesser disturbance of the mental process than true paranoia, hence the brain must be less impaired.

The following case of typical mysophobia (*folie du doute avec délire du toucher*), shows one of the milder types of the disease, although theoretically belonging to the second stage. Here there was a speedy recovery, and no special taint. In the case of Mrs. R., already cited, although nominally in the first stage, the condition was much more persistent, and was complicated with a bad heredity.

Miss G., aged eighteen, consulted me on the 16th of April, 1888. Her father and sister are "quite nervous," beyond that I could get no special history of a neurotic taint. She, herself, is a slight, anæmic underdeveloped girl, a student in one of our higher schools. For some months she has been working hard at school, and has been slowly losing strength; her appetite is poor, she has a tired feeling in the chest, menstruation is irregular. She consulted a physician, who prescribed a tonic containing iron, which she took with some benefit. About a month ago, however, she began to feel that she must use especial care in rinsing out the glass she took her medicine in, otherwise it would cause trouble. She began to be fearful of poison. She felt that she must wash

her hands with great care lest ammonia should get on them. The trouble increased, and she began to feel that she must repeat the washings in order to be sure that no poison or ammonia could get on her. If she tries to overcome the feeling she has a headache. If she neglects her washings she has a predominating idea that some one will be hurt if she does not repeat them. She was ordered to leave school, and a course of baths, feeding, and an out-door life was prescribed. She was assured that no harm could come to her or to any one if the washings were neglected, and she was urged to resist any inclinations to yield to these involuntary representations. A week later she reported improvement, she can overcome her feelings better and they are less strong, but she still has the feeling that she has been careless, she knows she really has not been careless, yet the doubt continues. The treatment was continued, further encouragement and assurances were given her, and two weeks later, on the 7th of May, she reported that she had no more trouble.

Some years ago I had the opportunity to observe at the Boston Lunatic Hospital a patient who was apparently in the third stage of insanity of doubt. The case has already been reported by Dr. Boland,[1] so that I will refer only to certain points in the case. There were certain fears of wrong doing, and the patient had to repeat her words and acts five times to be sure that they were right. These repetitions weary her so much that she will sit for hours motionless, dreading to move lest the act should require repetition. She becomes somewhat depressed, and from this dread of the repetitions, is careless of her dress. At the first glance her expression and attitude are that of a patient with melancholia attonita. In spite of her being apparently in the third stage, she has recovered from three similar attacks, (I saw her in the third) and is now undergoing a fourth. As a matter of fact insanity of doubt may begin with or very soon pass into any stage, and any stage may be recovered from.

Although, however, many of the cases of insanity of doubt have no psychopathic taint behind them, it is a curious fact that imperative representations (of a non-affective character) are rarely met with in neurasthenia. On going over one hundred consecutive cases, I found such symptoms noted in only one. Neurasthenic patients are timorous, doubtful, and need constant re-assurance, but true insistent ideas are rare.

[1] Boland, Boston Med. and Surg. Journ. 9 April, 1885.

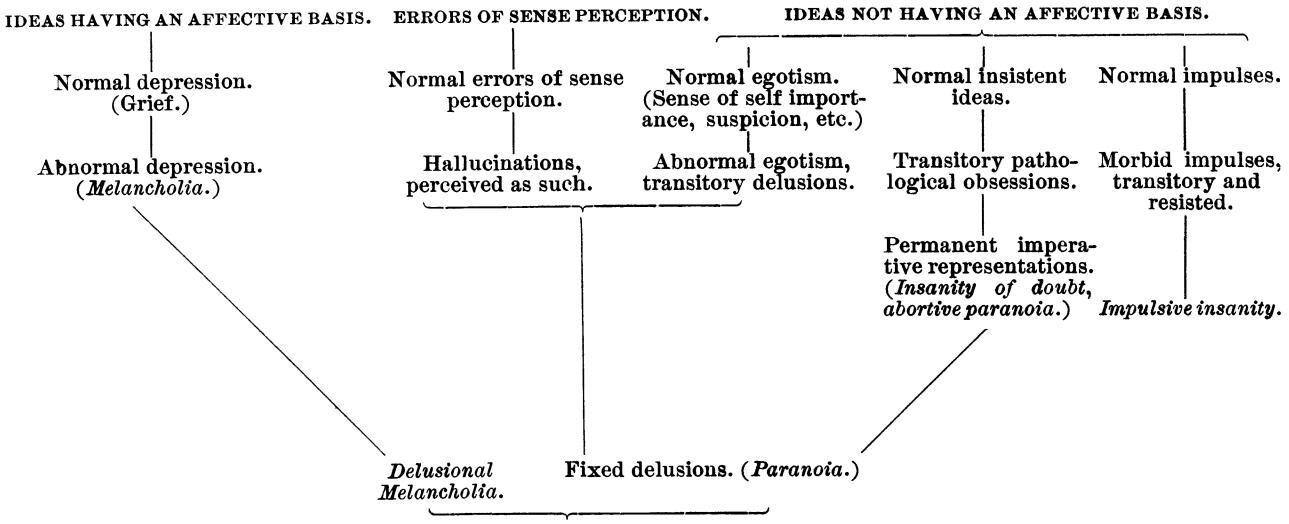
Many authors class the various morbid fears, agoraphobia, claustrophobia, etc., with the insanity of doubt. The classification seems erroneous. The victim of agoraphobia has a sudden attack of morbid fear under certain external conditions. It rarely happens that his fears have anything to do with previous processes of ideation, and it is still more rare to find the slightest trace of anything like an insistent idea. There is rarely any element of doubt or hesitancy, but a sudden physical inability to perform an act. Agoraphobia, and its kindred affections, form a class in the intention psychoses recently described by Meyer[1], and have little to do with the insanity of doubt, although one of Krafft-Ebing's patients, who had imperative representations, had also agoraphobia. Some victims of agoraphobia, however, are haunted by their morbid fear, even when in the house, thus showing a gradation between the intention psychosis and the imperative representation.

Impulsive insanity, (homicidal mania, etc.,) is so strongly differentiated from the insanity of doubt, that, although based on imperative representations, it must be put in a separate group. In the insanity of doubt there is an imperative representation, with incessant speculation and hesitancy, and finally numberless petty acts and an inability to perform the necessary duties of life. In impulsive insanity there is an imperative representation leading to the performance of a single act; this is resisted for a time, but finally the impulse becomes irresistible, and the discharge takes place. In the one there is paralysis of volition, in the other a convulsive discharge.

The following table will represent the genesis of the various representations and the relations of certain forms of insanity to the insanity of doubt:

[1] Meyer, Arch .f. Psychiatrie, xx, 1888.

TABLE I.


IDEAS HAVING AN AFFECTIVE BASIS.
ERRORS OF SENSE PERCEPTION.
IDEAS NOT HAVING AN AFFECTIVE BASIS.
Normal depression. (Grief.)
Abnormal depression. (*Melancholia.*)
Normal errors of sense perception.
Hallucinations, perceived as such.
Normal egotism. (Sense of self importance, suspicion, etc.)
Abnormal egotism, transitory delusions.
Normal insistent ideas.
Transitory pathological obsessions.
Permanent imperative representations. (*Insanity of doubt, abortive paranoia.*)
Normal impulses.
Morbid impulses, transitory and resisted.
Impulsive insanity.
Delusional Melancholia.
Fixed delusions. (*Paranoia.*)

It may be added that in insanity of doubt certain physical symptoms are noted: Headache, pain, præcordial distress, tremor, vertigo, tinnitus, vaso-motor disturbances, loss of appetite, insomnia, etc.

The prognosis is regarded by almost all writers as very bad; but the majority of them look upon insanity of doubt as a psychical degeneration. Spitzka alone says that many of the mild cases get well in three months. From what has been already said it is plain that Spitzka's view seems more correct. The important factor in prognosis is the existence of a hereditary taint. In well marked cases, where this exists, the outlook is, of course, bad.

Beside the ordinary tonic treatment, rest, forced feeding, etc., stress must be laid upon mental and physical gymnastics. The necessity for doing certain acts in regular repetition, for repeated efforts of volition, such as are required, for instance, in using the chest weights, may have a beneficial result on other mental processes.

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See also the treatises of Krafft-Ebing, Emminghaus, Spitzka, Ball, Maudsley and Hammond. Reports of single cases are omitted.